Health Services
LOS ANGELES COUNTY

May 19, 2009

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To improve health through leadership, service and education

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL OF HEALTH CARE COVERAGE INITIATIVE AGREEMENT WITH THE STATE DEPARTMENT OF HEALTH CARE SERVICES (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval to sign Health Care Coverage Initiative Agreement with the State Department of Health Care Services.

IT IS RECOMMENDED THAT YOUR BOARD:

Approve and authorize the Interim Director of the Department of Health Services (DHS), or his designee, to execute Agreement No. 07-1448-LA19 with the State Department of Health Care Services (DHCS): Health Care Coverage Initiative to expand health care coverage to eligible low income, uninsured adults that qualify and enroll in the County's Health Care Coverage Program known as Healthy Way LA (HWLA), in the amount of $54.0 million dollars annually for each of the three Program Years, effective September 1, 2007 through August 31, 2010.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

On February 12, 2008, DHS advised your Board that on April 10, 2007, DHS received its Notice of Allocation from the DHCS in the amount of $54.0 million dollars per year for three program years, effective September 1, 2007 through August 31, 2010. At that time your Board was also advised that DHCS and DHS were in the process of finalizing the Coverage initiative Agreement between the State and the County. Pending completion of that Agreement, the State represented that claims for services provided in anticipation of a final agreement would be honored, and your Board's approval allowed DHS to initiate services through the HWLA provider network.

Following ongoing agreement language negotiations concerning program and financial requirements, the State provided the final Coverage Initiative Agreement for DHS signature on April, 10, 2009.

The recommended action will allow the Interim Director to sign the Agreement, substantially similar to Exhibit I, for Covered Services provided under the Health Care Coverage Initiative effective September 1, 2007 through August 31, 2010. The Coverage Initiative Agreement needs to be signed and executed by the State in order for DHS to receive funds. The allocation for each Program Year is considered an annual allotment for Covered Services rendered during the Program Year. Any unspent dollars are not allowed to roll over for Covered Services rendered in subsequent Program Years.

Currently the HWLA Service Network includes 21 DHS hospital and non-hospital based clinics and 31 contracted Public Private Partnerships (PPPs) with a combined total of about 99 sites. The HWLA Program is designed to provide patients with medical homes, with an emphasis on preventive services and coordinated chronic disease care. The expected outcome is improved health status for patients through more appropriate service utilization.

Implementation of Strategic Plan Goals

The recommended action support Goal 1, Operational Effectiveness and Goal 4, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Revenue in the amount of $54.0 million dollars was included in the Fiscal Year (FY) 2007-08 and FY 2008-09 Final Budgets, and the same amount of $54.0 million has been included in the FY 2009-10 Proposed Budget in accordance with the terms of the DHCS Health Care Coverage Initiative Agreement.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

In August 2005, the federal Centers for Medicare and Medicaid Services approved California's five year 1115 Medi-Cal Hospital/Uninsured Care Demonstration (Demonstration). Under the Demonstration, the DHCS made federal funds available to qualifying counties for the expansion of health care coverage through the Health Care Coverage Initiative.

The final DHCS Health Care Coverage Initiative Agreement was received from the State for signature on April 10, 2009.

The HWLA eligibility criteria requires that the patient is an uninsured resident of Los Angeles County, low-income (at or below 133 1/3 percent of the Federal Poverty Level), a U.S. Citizen or legal resident for five years or more, a current patient at a DHS or PPP facility during the past year, and between 19 and 64 years of age.

The DHCS Health Care Coverage Initiative Agreement may be terminated with or without cause by the County with 30 days written notice to DHCS.

County Counsel and outside counsel, Foley and Lardner LLP, have reviewed and approved the DHCS Health Care Coverage Initiative Agreement, as to form.

CONTRACTING PROCESS

The DHCS Health Care Coverage Initiative Agreement is not a contracting opportunity.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended Agreement will maximize potential revenue for DHS.

CONCLUSION

When approved, DHS requires three signed copies of the Board's action.

Respectfully submitted,

Gregory Pall

For John F. Schunhoff, Ph.D.
Interim Director

JFS:id

Attachment

c: Chief Executive Officer
Acting County Counsel
Executive Officer, Board of Supervisors

HWLA BL

EXHIBIT I

CONTRACT FOR HEALTH CARE COVERAGE PROGRAM: HEALTH CARE COVERAGE INITIATIVE

Department of Health Care Services Contract No. 07-1448-LA19

Governmental Entity (Contractor): County of Los Angeles

Address: County of Los Angeles
Department of Health Services
313 N. Figueroa Street, Room 912
Los Angeles, CA 90012

This Contract is not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

ARTICLE 1

FORMATION

1.1 Identification of Parties

This Contract is between the Department of Health Care Services, hereinafter designated "Department," and the County of Los Angeles, hereinafter designated "Contractor."

1.2 Term of Contract

Except as set forth in Article 6 with respect to claiming of allowable administrative costs, this Contract is effective for Covered Services provided under the Health Care Coverage Initiative (Coverage Initiative) beginning on September 1, 2007, and will continue until August 31, 2010, unless terminated under the provisions of this Contract.

1.3 Allocation

The maximum amount of Federal Financial Participation allocated to Contractor for Covered Services annually will be Fifty-Four Million Dollars ($54,000,000) for each of the three Program Years from September 1, 2007, through August 31, 2010. In addition to Contractor's allocation for Covered Services, Federal Financial Participation is available for allowable administrative costs pursuant to Article 6.

The Allocation for each Program Year is considered an annual allotment for Covered Services rendered during the Program Year. Any unspent dollars are not allowed to roll over for Covered Services rendered in subsequent Program Years. Claims may be made and payments may be received for Covered Services rendered in prior Program Years, subject to the two-year time limit on filing of claims pursuant to Section 1320-b of Title 42 of the United States Code.

1.4 Department's Authority to Contract

This Contract is formed under the authority of Division 9, Part 3.5 (commencing with Section 15900) of the Welfare and Institutions Code governing the Coverage Initiative, and Title 1, Division 7, Chapter 5, Article 1 (commencing with Section 6500) of the Government Code establishing a procedure for the exercise of powers, by the contracting parties, when those parties are within the definition of the term "Public Agency" set forth in Section 6500 of the Government Code.

1.5 Governing Authorities

(a) This Contract will be governed and construed in accordance with:

(1) The Special Terms and Conditions of the section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration (Demonstration) – Waiver No. 11-W-00193/9, any Demonstration implementation documents approved by the Centers for Medicare & Medicaid Services (CMS), applicable Medicaid state plan amendments, Article 5.2 (commencing with Section 14166) of the Welfare

and Institutions Code, and Division 9, Part 3.5 (commencing with Section 15900) of the Welfare and Institutions Code.

(2) Part 3, Division 9 of the Welfare and Institutions Code, as applicable; Divisions 3 and 5 of Title 22 of the California Code of Regulations, as applicable; and all other applicable state laws and regulations according to their content on and after the effective date stipulated in Paragraph 1.2.

(3) Titles 42 and 45 (Part 74) of the Code of Federal Regulations as applicable and all other applicable federal laws and regulations according to their content on and after the effective dates stipulated in Paragraph 1.2, except those provisions or applications of those provisions waived by the Secretary of the United States Department of Health and Human Services, or otherwise inapplicable under the Special Terms and Conditions of the Demonstration.

(b) The governing authorities identified in subparagraphs (1) through (3) will govern, as applicable, the administrative activities and cost claiming in Article 6 according to their content on and after the effective date of March 29, 2007.

(c) Any provision of this Contract in conflict with the laws or regulations set forth in subparagraph (a) of this Paragraph is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract will be effective on the effective date of the statute or regulation necessitating it, and will be binding on Department and Contractor even though such amendment may not have been reduced to writing and formally agreed upon and executed by Department and Contractor as provided in Paragraph 8.5.

1.6 Conformance with Federal Regulations

Contractor agrees that this Contract, in part, implements Title XIX of the Federal Social Security Act and, accordingly, covenants that it will conform to such requirements and regulations as the United States Department of Health and Human Services may issue from time to time, to the extent that the requirements apply under the Demonstration.

1.7 Declaration of Present Contractual Intent

Department and Contractor, in consideration of the covenants, conditions, stipulations, terms and warranties hereinafter expressed, agree to contract for the purpose of expanding health care coverage to low-income, uninsured individuals pursuant to Section 15900, et seq., of the Welfare and Institutions Code and the Special Terms and Conditions of the Demonstration. Contractor will implement, only to the extent that Federal Financial Participation is available, a Health Care Coverage program for Eligible Individuals pursuant to the Demonstration and State law by making available to Enrollees the covered health care services attached hereto as Exhibit A, entitled Covered Services.

1.8 Declaration That Enrollees in The Health Care Coverage Program Are Not Third Party Beneficiaries Under This Contract

Notwithstanding mutual recognition that Covered Services under this Contract will be rendered to Enrollees through Contractor's Health Care Coverage program, as set forth in Paragraph 3.8, it is not the intention of either Department or Contractor that such Enrollees occupy the position of intended third party beneficiaries of the obligations assumed by either Department or Contractor.

ARTICLE 2

DEFINITIONS

2.1 General Meaning of Words and Terms

The words and terms used in this Contract are intended to have their usual meanings in any of the governing authorities identified in Paragraph 1.5 pertaining to the rendition of Covered Services, or unless specifically defined in this Article or otherwise in this Contract.

For purposes of this Contract the terms "Governmental Entity" and "Contractor" are synonymous.

2.2 Allocation

Allocation means the maximum annual amount of Federal Financial Participation available as reimbursement for the expenditures made by the Contractor in the implementation of its Health Care Coverage program for Covered Health Care Services. Allocation does not include Federal Financial Participation for reimbursement of the allowable costs of administrative activities, pursuant to Article 6.

2.3 Case Management

Case Management means the services which will assist individuals enrolled under the Coverage Initiative in gaining access to needed medical and other services related to their changing medical needs to enhance care while, at the same time, managing costs, for the delivery of health care services for the Enrollees. For purposes of this Contract, there is no distinction made between the meaning of "care management" and the meaning of "Case Management." Case Management is an allowable administrative activity, as determined by CMS, for which Federal Financial Participation is available and for which Contractor may be paid pursuant to Article 6, in addition to its annual Allocation for Covered Health Care Services set forth in Paragraph 1.3. The allowable costs associated with Case Management will be captured through a time study methodology approved by CMS.

2.4 Certified Public Expenditure

Certified Public Expenditure means the allowable total funds expenditure that is certified by the Governmental Entity (Contractor) as representing an expenditure eligible for Federal Financial Participation under the Demonstration, and as authorized pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

2.5 Covered Health Care Services

Covered Health Care Services (Covered Services) means any health care service identified in Exhibit A, entitled Covered Services, which is provided by Contractor or its Subcontractor to an Enrollee within Contractor's target population and for which Federal Financial Participation is available under Contractor's Health Care Coverage program.

2.6 Direct Service Provider

Direct Service Provider means a hospital, clinic, licensed health care professional, or other entity that provides Covered Services to Enrollees.

2.7 Eligible Individual

Eligible Individual means an individual who qualifies to receive services under Contractor's Health Care Coverage program, who is low-income, uninsured, age 19 through 64, with income at or below 133⅓ percent of the Federal Poverty Level; has not had health insurance in the three months prior to enrollment at the time eligibility is determined except as provided in Paragraph 3.8(d)(3); and the Special Terms and Conditions of the Demonstration; and, is not eligible for the Medi-Cal Program, the Healthy Families Program, or the Access for Infants and Mothers Program.

2.8 Enrollee

Enrollee means an Eligible Individual who meets Section 6036 of the Deficit Reduction Act of 2005 regarding the satisfactory documentary evidence of United States citizenship and identity, and who has been enrolled into the Health Care Coverage program by Contractor.

2.9 Expand Health Care Coverage

Expand Health Care Coverage means to increase the number of Eligible Individuals who are provided health care coverage or to provide one or more new Covered Services to Eligible Individuals.

2.10 Federal Poverty Level

Federal Poverty Level refers to the poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the Code of Federal Regulations. The poverty

guidelines are used as an eligibility criterion for participation in Health Care Coverage programs.

2.11 Health Insurance

Health Insurance means any commercial insurance coverage that pays for all or part of a person's health care costs.

2.12 May

May is used to indicate a permissive or discretionary term under this Contract.

2.13 Medical Home

Medical Home means a provider or facility that maintains all of an Enrollee's medical information.

2.14 Program Year

Program Year means each of the following twelve-month periods:

Program Year One	September 1, 2007, through August 31, 2008;
Program Year Two	September 1, 2008, through August 31, 2009;
Program Year Three	September 1, 2009, through August 31, 2010.

2.15 Section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration/Coverage Initiative

Section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration (Demonstration) means the hospital financing waiver that provides $180 million in federal funds for each of the three Program Years from September 1, 2007, through August 31, 2010 for the development and implementation of the Coverage Initiative. The federal funding available under the Coverage Initiative will be used to reimburse Contractor for expanding health care coverage to eligible low-income, uninsured individuals.

2.16 Special Terms and Conditions of the Demonstration

Special Terms and Conditions of the Demonstration means the Agreement between the State of California and CMS. The Special Terms and Conditions of the Demonstration for California's section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration set forth in detail the nature, character, and extent of federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

2.17 Subcontractor

Subcontractor means an entity or person that enters into a contract with Contractor to provide one or more Covered Services for Enrollees, pursuant to this Contract as part of the Contractor's direct service provider network, or to perform administrative activities on behalf of the Contractor.

2.18 Will or must

Will or must is used to indicate a mandatory term under this Contract.

ARTICLE 3

CONTRACTOR'S PERFORMANCE PROVISIONS

3.1 General Agreement

(a) Contractor will make appropriate Covered Services available for Enrollees within Contractor's target population from the list of Covered Services as set forth in Exhibit A, entitled Covered Services.

(b) Contractor must provide and maintain, or subcontract with, facilities and professional, allied and supportive paramedical personnel to make appropriate Covered Services available for Enrollees.

(c) Contractor must provide and maintain, or subcontract for, the organizational and administrative capabilities to carry out its duties and responsibilities under this Contract.

(d) Contractor must maintain a copy of each subcontract entered into in support of this Contract and must, upon request by Department, make copies available for approval, inspection, or audit.

(e) Department assumes no responsibility for the payment of Subcontractors used in the performance of this Contract or any subcontract. Contractor accepts sole responsibility for the payment of Subcontractors used in the performance of this Contract or any subcontract.

(f) Contractor or Subcontractor on behalf of Contractor will perform all health care and administrative activities necessary to carry out the duties and responsibilities in the provision of Covered Services. Contractor is responsible for performance of all requirements under Articles 3, 6, and 7 of this Contract even though performance may be carried out through a Subcontractor.

(g) Contractor must ensure that all subcontracts for Covered Services include provision(s) requiring compliance with applicable terms and conditions specified in this Contract.

(h) Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for Covered Services provided under this Contract:

(Subcontractor Name) agrees to maintain and preserve records related to Covered Services provided to Enrollees for a period of three years from the date the service was rendered, to permit Department, CMS, or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers, and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records.

3.2 Estimated Expenditure Schedule

Contractor must make expenditures associated with the provision of its Covered Services based on an estimated annual expenditure schedule in order to ensure claiming the full allocation of Federal Financial Participation as specified in Paragraph 1.3 for each Program Year.

Expenditure schedules reflecting Contractor's annual expenditure estimates must be submitted by August 1st of each Program Year, on a form provided by Department. The August 1st date will be extended as necessity dictates in Program Year One. The final due date for the estimated expenditure schedule for Program Year One will be determined in consultation with Contractor. The date will be set as soon as practicable.

3.3 Reallocation of Federal Financial Participation

(a) If Contractor does not make expenditures associated with the provision of Covered Services in accordance with the estimated annual expenditure schedule, as determined by Department at the end of the second quarter of each Program Year, Department may reduce the Allocation under this Contract in an amount equal to that portion of the Allocation that Department determines, based on available data, is not claimable. Department may reallocate that amount to other Health Care Coverage programs.

(b) Before reallocating funds under subparagraph (a), Department will provide Contractor with an opportunity to submit a revised expenditure schedule with supporting documentation to demonstrate that Contractor can expend the amount necessary by the end of the Program Year to claim its entire Allocation.

3.4 Supplement Not Supplant Existing Health Care Services Programs

Contractor must ensure that its Allocation supplements, and does not supplant, any county, city and county, health authority, state, or federal funds that would otherwise be spent by Contractor on health care services in its county. Contractor will comply with this requirement by demonstrating that, the annual amount of non-federal funds expended by Contractor for health care services provided to the indigent are maintained at, or increased above, those expenditures for State Fiscal Year 2006-07, which are identified in Exhibit E entitled Maintenance-of-Effort, as the Maintenance-of-Effort requirement. For purposes of determining compliance with this Section, the annual amount of non-federal funds expended by Contractor for health care services for the indigent shall be determined using data and accounting methods consistent with those used in Exhibit E and shall be submitted to Department annually for review.

If any change in federal or State law results in a significant reduction in the number of uninsured indigent individuals in the State during the term of this Contract, the parties shall, in good faith, negotiate an amendment to this Section of the Contract that takes into account the reduction.

If the Contractor does not meet the annual Maintenance-of-Effort requirement, CMS may reduce Federal funding for the Coverage Initiative by the amount of the deficiency and the Contractor's Allocation may be reduced by the Department.

Funding, such as a grant, that is currently received from a particular source that is specifically targeted for a specified purpose or program cannot be used as the non-federal share of funds for programs under the Coverage Initiative.

3.5 Health Care Coverage Program Monitoring and Evaluation

Contractor must cooperate with, and provide necessary data to Department or Department's agents and CMS in order to perform required program monitoring and mandated program evaluation. Any data provided to the Department as part of program progress reports may also be used for program monitoring and mandated program evaluation. At a minimum, the evaluation will include a determination as to how well Contractor achieves all of the following outcomes:

(a) Expand the number of Californians who have health care coverage.

(b) Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, county clinics, and community clinics.

(c) Improve access to high quality health care and health outcomes for individuals.

(d) Create efficiencies in the delivery of health services that could lead to savings in health care costs.

(e) Provide grounds for long-term sustainability of the programs funded under the Coverage Initiative.

(f) Implement programs in an expeditious manner in order to meet federal requirements regarding the timing of expenditures.

In addition, to meet CMS requirements, the evaluation must include program income and expenditures.

3.6 Service Locations

Contractor or Subcontractors will make available Covered Services at the service location(s) set forth in Exhibit B, entitled Health Care Coverage Program Direct Service Providers. Exhibit B may be amended by Contractor upon notice to Department pursuant to Paragraph 8.4. Amendments to Exhibit B do not require prior federal or Department approval, and will be effective five (5) business days after notice has been provided to Department, provided that the amendment does not alter the overall outcomes and basic purpose of this Contract pursuant to Paragraph 8.5(a).

3.7 Health Care Coverage Program Progress Reports

Contractor must submit an annual and quarterly Health Care Coverage program progress reports and data according to instructions, as required by Department. Unless otherwise directed by Department, the quarterly progress reports will include, but not be limited to:

(a) Program specific data including, but not limited to, number of Enrollees; demographics; number and type(s) of service(s) per Enrollee; number of inpatient bed days; outcomes,

activities, and efficiencies in the delivery of health care services; and, trends in emergency room usage.

(b) Service utilization and cost data including, but not limited to, average cost per Enrollee and number of Enrollees per month.

(c) Program status data including, but not limited to, a determination of quality of health care delivered and assessed in part through health outcomes, access, cost-sharing, case study findings; and a summary of the types of grievances, complaints or problems Enrollees identified about the program in the applicable quarter, including any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.

(d) In addition to items specified in (a), (b), and (c) above, Contractor will include an assessment of reduction in emergency room usage in the fourth quarterly program progress report for each Program Year.

(e) At a minimum, the annual progress report for each Program Year will reflect consolidated data for the Program Year and annual program trends associated with items specified in (a) through (d) above, as well as discussion of outcomes and any discernable impacts to the delivery of health care services in the county as a result of implementing the Health Care Coverage Program.

3.8 Work to Be Performed

(a) Contractor will make available Covered Services to Enrollees in accordance with Exhibit A, entitled Covered Services. Contractor may request limiting or removing any Covered Service from Exhibit A, by providing notice to Department in accordance with Paragraph 8.4. Contractor amendments are subject to the requirements of Paragraph 8.5 and require Department approval. Any service Contractor wishes to add beyond the scope of Covered Services in Exhibit A will require CMS approval pursuant to Section III, Paragraph 7 of the Special Terms and Conditions of the Demonstration.

(b) Contractor must adhere to limits in cost-sharing, premiums, and enrollment fees in accordance with the Special Terms and Conditions of the Demonstration, as identified in Exhibit C, entitled Covered Services Maximum Cost Sharing. Contractor does not intend to impose cost-sharing, premiums or enrollment fees initially, and must not begin imposing cost-sharing, premiums, or enrollment fees without CMS approval pursuant to Section III, Paragraph 7, of the Special Terms and Conditions of the Demonstration.

(c) Contractor must utilize an identification card system and unique Enrollee identifier for each Enrollee in its Health Care Coverage program.

(d) Contractor must screen and assess potential Enrollees to determine eligibility for enrollment into the Health Care Coverage program. Enrollment is effective on the date of application or the first day of the month in which the Health Care Coverage program application was submitted. Coverage can begin no earlier than September 1, 2007. Eligibility criteria must include, but is not limited to, the following:

(1) Enrollee income must not exceed 133⅓ percent of the Federal Poverty Level. Contractor must verify the Enrollee's income. When income documentation has been requested by Contractor and has not been received, such income documentation shall be deemed satisfied if both of the following occur:

(a) Contractor obtains a statement signed by the applicant/enrollee or his/her authorized representative acknowledging that the applicant/enrollee has been instructed to provide income verification documents but, after two weeks, the documents have not been received by the Contractor.

(b) Income was previously reported by means of a sworn affidavit signed under penalty of perjury by the applicant/enrollee or his/her authorized representative as part of either of the following application processes:

(i) The County Outpatient Reduced-Cost Simplified Application (ORSA) or through the Public-Private Partner (PPP) Certificate of Indigency (COI) processes previously approved under the Medicaid Demonstration Project for Los Angeles County.

(ii) Another application process that requires income to be reported using a sworn affidavit signed under penalty of perjury.

(2) Enrollees must be between the ages of 19 through 64.

(3) Enrollees with incomes between 101-133⅓ percent of the Federal Poverty Level must not have had commercial health insurance coverage in the three months prior to enrollment unless the individual had employer- sponsored commercial health insurance coverage and one of the following events occurred in the three months prior to application for the Health Care Coverage program:

a. Loss of job.

b. A move to a zip code area or region that is not covered by the employer-sponsored health insurance.

c. Loss of health insurance because the employer stopped providing health insurance for all employees.

d. A divorce or legal separation from the individual whose employer provides health insurance.

e. The death of the individual who is the subscriber of the employer-sponsored health insurance.

f. Termination or cancellation of the individual's Consolidated Omnibus Budget Reconciliation Act (COBRA) policy.

Contractor may accept Enrollee's self-declaration regarding prior health insurance.

(4) United States citizenship and identity documentation requirements must be met in accordance with Section 6036 of the Deficit Reduction Act of 2005, entitled Improved Enforcement of Documentation Requirements.

a. Eligible Individuals must not be enrolled in the Health Care Coverage program until they have presented the required evidence, and United States citizenship, and identity, are verified.

b. Individuals transitioning from one county Health Care Coverage program to another must meet Contractor's eligibility and enrollment requirements.

(5) Eligible Individuals can not be eligible for the Medi-Cal program, the Healthy Families program, or the Access for Infants and Mothers program.

(6) No asset test will be imposed upon Enrollees.

(e) Contractor must use the local health department's or social service department's government employees, to determine eligibility as required pursuant to the Special Terms and Conditions of the Demonstration. However, non-government employees may prepare documents, develop eligibility packages and make recommendations to local government employees who must make the final eligibility determination.

(f) Contractor must designate a Medical Home for each Enrollee to ensure that he/she has access to primary and preventive services.

(g) Contractor must assess the health care outcomes of Enrollees through quality monitoring.

(h) Contractor must conduct periodic utilization reviews for Case Management to evaluate whether the Covered Services provided are consistent with program utilization projections and meet the needs of the target population.

(i) Contractor must provide consumer assistance to individuals applying to, participating in, or accessing services in the program.

(j) Contractor must promote the Health Care Coverage program in the community and conduct outreach that provides information about the program and encourages eligible low-income, uninsured individuals to apply.

(k) Contractor must promote the use of preventive services and early intervention to Enrollees.

(l) Contractor must use a medical records system which may include the use of electronic medical records.

(m) Contractor must implement medical records management processes and controls to identify and reduce medical errors and eliminate duplication of services.

3.9 Assumption of Risk by Governmental Entity

Contractor will bear total risk for the cost of all Covered Services rendered by Contractor to Enrollees. As used in this Paragraph, "risk" means that the Contractor covenants to accept as payment in full for such Covered Services, payments by the Department in an amount equal to the Federal Financial Participation amount of Contractor's allowable Certified Public Expenditures under this Contract. Such acceptance will be made irrespective of whether the cost of such Covered Services will have exceeded the payment obligation matured under the conditions set forth in this Contract.

3.10 Non-Binding Estimates of Annual Enrollment Levels

Contractor projects, but is not bound by, the following annual enrollment levels at the end of each Program Year:

Estimated Enrollees for Program Year One: 94,000

Estimated Enrollees for Program Year Two: 94,000

Estimated Enrollees for Program Year Three: 94,000

ARTICLE 4

DEPARTMENT'S RESPONSIBILITIES

4.1 Claiming for Federal Financial Participation

(a) Covered Services

Department will claim Federal Financial Participation for the reimbursement of Certified Public Expenditures incurred by Contractor under its Health Care Coverage program for Covered Services. Department will timely pay Contractor the total Federal Financial Participation amount received pursuant to such claims which are accurate and consistent with the federally approved Certified Public Expenditures for Covered Services claiming methodology developed by the Department. With respect to Certified Public Expenditures for Covered Services, payment to Contractor will not exceed the Allocation amount specified in Paragraph 1.3 of the Contract for Covered Services rendered in each Program Year.

(b) Administrative Activities

Department will claim Federal Financial Participation for the reimbursement of allowable costs associated with federally approved direct and indirect administrative activities. Department will timely pay Contractor the total Federal Financial Participation amount received pursuant to such claims which are accurate and consistent with the federally approved direct and indirect administrative activities and cost claiming methodology developed by the Department.

4.2 Health Care Coverage Program Monitoring

Department will monitor the progress of Contractor's Health Care Coverage program to determine compliance with the terms of this Contract, State and federal law, and the Demonstration, pursuant to Paragraph 3.5. This responsibility includes the review and assessment of program income, expenditure patterns, and trends.

4.3 Reallocation of Federal Financial Participation

Department may reduce the Allocation under this Contract and reallocate the remaining federal funds to other Health Care Coverage programs if Contractor does not meet its estimated expenditure schedule, as determined by Department at the end of the second quarter of each Program Year. Department will provide Contractor with an opportunity to submit a revised estimated expenditure schedule with supporting documentation to demonstrate that Contractor can expend the amount necessary by the end of the Program Year to claim its entire Allocation for that Program Year. The amount that may be subject to reallocation is limited to that portion of Contractor's Allocation that the Department reasonably anticipates would remain unclaimed in Federal Financial Participation for Covered Services rendered by the Contractor in a particular Program Year.

ARTICLE 5

PAYMENT PROVISIONS

5.1 Certified Public Expenditures

(a) In consultation with Contractors, Department will develop, and obtain federal approval of, a methodology for identifying, reporting, and claiming Certified Public Expenditures for Covered Services incurred by Contractor under the Health Care Coverage program. The methodology will provide for interim payments to Contractor and, to the extent possible, will be consistent with the cost finding methodology currently approved under the Demonstration.

(b) Governmental Entity (Contractor) must incur the allowable total funds expenditures for Covered Services and must certify and report these expenditures, according to a federally approved Certified Public Expenditures methodology, as representing expenditures eligible for Federal Financial Participation authorized pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. Federal reimbursement under the Health Care Coverage program will be available up to the yearly Allocation in Paragraph 1.3. If Contractor does not make the required expenditures, Department may reduce Contractor's Allocation as set forth in Paragraph 4.3 above.

(c) Contractor's certification ensures all of the following:

(1) That expenditure reports are accurate and consistent with the federally approved Certified Public Expenditures for Covered Services reporting methodology developed by the Department and approved by CMS;

(2) That the expenditures comply with Section 433.51 of Title 42 of the Code of Federal Regulations; and,

(3) That the sources of funds used to make the allowable expenditures do not include impermissible provider taxes or donations as defined under Section 1396b (w) of Title 42 of the United States Code, or other federal funds. For this purpose, federal funds do not include patient care revenue received as reimbursement for services rendered under programs such as Medicare or Medicaid.

(d) Department will reimburse to Contractor an amount equal to the Federal Financial Participation received by the Department at the applicable Federal Medical Assistance Percentage, for providing Covered Services. No State money, general fund or otherwise, will be available to support any payments under this Contract.

(e) Contractor must submit its Certified Public Expenditures for Covered Services to Department, in a format and according to a schedule determined by Department in consultation with Contractor. Department will submit a claim for Federal Financial Participation to reimburse Contractor the federal share of its total funds expenditures up to the amount of the annual Allocation.

(f) Federal Financial Participation will not be available for expenditures incurred in providing Covered Services to individuals enrolled after March 1, 2010, pursuant to the Special Terms and Conditions of the Demonstration, unless directed otherwise by the Department.

ARTICLE 6

ADMINISTRATIVE ACTIVITIES AND COST CLAIMING

6.1 Administrative Activities

(a) Contractor will perform all administrative activities necessary to carry out its duties and responsibilities in the provision of its Covered Services.

(b) In consultation with Contractor, Department will develop and obtain federal approval of a methodology for identifying, reporting, and claiming direct and indirect administrative activities and costs incurred by Contractor under the Health Care Coverage program for those allowable direct and indirect administrative activities including start up, implementation, and close-out for which Federal Financial Participation is available under the Demonstration.

(c) Contractor must submit its administrative activities budget projection to Department by August 1st of each Program Year, on a form provided by Department. The August 1st date will be extended as necessity dictates in Program Years One and Two. The final due date for the administrative activities budget projection for the Program Years One

and Two will be determined in consultation with Contractor. The date will be set as soon as practicable.

(d) Contractor must submit to Department a revised administrative activities budget projection by March 1st of each Program Year for any change to the total budget amount that results in a five percent or greater increase to the total budget for each Program Year to allow Department to appropriately plan for budgeting of payments to Contractor.

(e) Department will claim Federal Financial Participation for all allowable costs associated with federally approved direct and indirect administrative activities.

(f) Department will reimburse to Contractor an amount equal to Federal Financial Participation received by Department at the applicable Federal Medical Assistance Percentage, for all allowable costs associated with federally approved direct and indirect administrative activities related to its Health Care Coverage program, including, start-up, implementation, and close-out costs that are incurred on or after March 29, 2007, through August 31, 2010. No State money, general fund or otherwise, will be available to support any payments under this Contract.

(g) Contractor will be reimbursed for all allowable direct and indirect administrative costs through a cost claiming process based on a direct administrative activities time study process approved by CMS on forms as specified by Department. Department will provide Contractor with reporting and claiming forms and technical assistance on the cost claiming process. Any reimbursement for allowable direct and indirect administrative costs received by Contractor will be in addition to the Allocation in Paragraph 1.3 of this Contract and is not limited to the administrative activities budget projection.

ARTICLE 7

RECORDS RETENTION, CONFIDENTIALITY, ACCESS, AND AUDIT PROVISIONS

7.1 Records to Be Kept; Audit or Review; Availability; Period of Retention

Contractor:

(a) Must keep and maintain records of each Covered Service rendered, the provider of the Covered Services, the Enrollee to whom the Covered Service was rendered, the date the Covered Service was rendered, and such additional information as Department and CMS may require. Records herein required to be kept and maintained will be retained by Contractor for a period of three years from the date the Covered Service was rendered.

(b) Must maintain books, records, documents and other evidence, accounting procedures and practices sufficient to reflect properly all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Contract. Contractor's

books and records must be maintained in accordance with generally accepted accounting principles as applicable to government entities.

(c) Must ensure the maintenance of medical records required by Sections 70747-70751 of Title 22 of the California Code of Regulations, and other records related to an Enrollee's eligibility for Covered Services, the Covered Service(s) rendered, the provider of Covered Service(s), the Enrollee to whom the Covered Service(s) was rendered, the date of the service(s), the medical necessity of the service(s), and the quality of the care provided. Records must be maintained in accordance with Section 51476 of Title 22 of the California Code of Regulations. The foregoing constitutes "records" for the purposes of this Paragraph.

(d) Will be subject at all reasonable times to inspection, audit, and reproduction of records by any duly authorized agents of the Department, the United States Department of Health and Human Services, and Comptroller General of the United States.

(e) Must preserve and make available its records relating to payments made under this Contract for a period of three years from the date the service was rendered, or for such longer period, as may be required by subparagraphs (1) and (2) below.

(1) If this Contract is terminated, the records relating to the work terminated must be preserved and made available for a period of three years from the date the last service was rendered under the Contract.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three year period, the related records must be retained until completion and resolution of all issues arising therefrom or until the end of the three year period, whichever is later.

(f) Will ensure that Subcontractors comply with Article 7 of this Contract.

7.2 Onsite Reviews

(a) Department and/or CMS may conduct periodic audits or reviews, including onsite audits or reviews of performance under this Contract. These audits or reviews may, at a minimum, evaluate the following:

(1) Contractor's compliance with Paragraph 3.8 of this Contract.

(2) Level and quality of care, and the necessity and appropriateness of the Covered Services provided.

(3) Internal procedures for assuring efficiency, economy, and quality of care.

(4) Grievances relating to medical care and their disposition, or any other types of complaints or problems.

(5) Financial records, when determined necessary by Department.

(b) Contractor must make adequate office space available for the review team or auditors to meet and confer. Such space must be capable of being locked and secured to protect the work of the review team or auditors during the period of their onsite review.

(c) Onsite reviews and audits will occur during normal working hours with at least seventy-two (72) hours notice, except that unannounced onsite reviews and requests for information may be made in those exceptional situations where arrangement of an appointment beforehand is clearly not possible or clearly inappropriate to the nature of the intended visit.

ARTICLE 8

GENERAL PROVISIONS

8.1 Integration Clause

Department and Contractor declare that this Contract, including its Exhibits, contain a total integration of all rights and obligations of the Department and Contractor. There are no extrinsic conditions or collateral contracts or undertakings of any kind. In regarding this Contract and its Exhibits as the full and final expression of their agreement, it is the express intention of both Department and Contractor that any and all prior or contemporaneous contracts, promises, negotiations, or representations, either oral or written, relating to the subject matter and period of time governed by this Contract and its Exhibits that are not expressly set forth herein, are to have no force, effect, or legal consequence of any kind.

8.2 Appeal Rights

Contractor (the governmental entity) will be entitled to pursue all administrative and judicial review available pursuant to Welfare and Institutions Code Section 14166.24 for costs incurred under the Coverage Initiative.

8.3 Contract Officer - Delegation of Authority

Department will administer this Contract through a single administrator, the Contract Officer. Until such time as the Department Director gives Contractor written notice of successor appointment, the person designated will make all determinations and take all actions necessary to administer this Contract, subject to the limitations of California law, federal law, and applicable regulations. No person other than the Contract Officer or the Director will have the power to bind Department relative to the rights and duties of Contractor and Department under this Contract, nor will any other person be considered to have the delegated authority of the Contract Officer or to be acting on his/her behalf unless the Contract Officer has expressly stated in writing that that person is acting as his/her authorized agent.

8.4 Notice

Any notice required to be given pursuant to the terms and provisions of this Contract and all proposed amendments to this Contract must be in writing and sent to the other party by first

class, certified, or registered mail with postage prepaid, and a return receipt requested. All notices and proposed amendments mailed in accordance with this paragraph will be deemed delivered five (5) business days after mailing.

Notice to Department must be sent to the following address:

Contract Officer
Department of Health Care Services
Safety Net Financing Division
Hospital/Uninsured Care Demonstration Section
Hospital Financing Data Unit
1501 Capitol Avenue, MS 4519
P.O. Box 997419
Sacramento, CA 95899-7419

Notice to Contractor must be sent to: John F. Schunhoff, Interim Director at the following address:

County of Los Angeles
Department of Health Service
313 N. Figueroa Street, Rm. 912
Los Angeles, CA 90012

8.5 Contract Amendments

(a) Contractor or Department may propose amendments to this Contract provided such changes do not alter the overall outcomes and basic purpose of this Contract.

(b) Notice of any proposed amendment will be governed by Paragraph 8.4.

(c) Department may revise this Contract to include any agreed upon amendments.

(d) Amendments requiring federal approval, pursuant to the Special Terms and Conditions of the Demonstration, must be submitted to Department no later than one hundred twenty (120) calendar days prior to the date of implementation of the change and may not be implemented until approved by CMS.

(e) Amendments not requiring federal approval must be submitted to the Department no later than thirty (30) calendar days prior to the date of implementation of the change and may not be implemented until approved by the Department.

8.6 Toleration of Deviation from Terms of Contract Not to be Construed as Waiver

The informal toleration by either party of defective performance of any independent covenant in this Contract will not be construed as a waiver of either the right to performance or the express conditions which have been created in this Contract.

8.7 Contract Disputes and Informal Appeals

If there is a Contract dispute or disagreement, between Contractor and Department, the following two-step process must be followed:

(a) Contractor must submit a written statement to the Contract Officer within thirty (30) calendar days from the date the disagreement became known to Contractor. The statement must describe the matter in disagreement, factual statements justifying the Contractor's requested remedy, and the legal authority or other basis for Contractor's position. The Contract Officer must make a determination on the merits of the disagreement within sixty (60) calendar days after receipt of a complete statement. The Contract Officer will respond in writing to Contractor indicating the decision and the reasons therefore.

(b) If Contractor disagrees with the Contract Officer's decision, Contractor may appeal the decision to the Department's Chief Deputy Director of Health Care Programs within sixty (60) calendar days after receipt of the Contract Officer's written decision. Contractor's request for appeal must include a letter detailing why Contractor disagrees with the decision, Contractor's original statement, supporting documents, and a copy of Department's decision. Department's Chief Deputy Director of Health Care Programs, or designee, may meet with Contractor to review the issues raised. A written decision from Department's Chief Deputy Director of Health Care Programs, or designee, will be returned to Contractor within sixty (60) calendar days after receipt of Contractor's request for appeal.

8.8 Conflict of Interest

(a) Contractor is subject to the terms and conditions of Section 51466 of Title 22 of the California Code of Regulations as applicable pursuant to Sections 14022, 14124.5, 14030 and 14031 of the Welfare and Institutions Code.

(b) No state officer or state employee responsible for development, negotiation, contract management, or supervision of this Contract will have a financial interest in the Contract as that term is defined in Section 87103 of the Government Code and the regulations adopted pursuant thereto.

8.9 Confidentiality of Information

(a) Names of Enrollees receiving services are confidential and are to be protected from unauthorized disclosure in accordance with Section 205.50 of Title 45 of the Code of Federal Regulations; Sections 10850 and 14100.2 of the Welfare and Institutions Code; and, regulations adopted pursuant thereto. For the purpose of this Contract, all information, records, and data elements pertaining to Enrollees will be protected by Contractor from unauthorized disclosure.

(b) With respect to any identifiable information concerning Enrollees under this Contract that is obtained by Contractor, Contractor must:

(1) Not use any such information for any purpose other than carrying out the express terms of this Contract, except as otherwise required or permitted by State and federal law;

(2) Transmit promptly to Department all requests for disclosure of such information, except for requests from within the Contractor's network or requests by or on behalf of the Enrollee;

(3) Not disclose, except as otherwise specifically permitted by this Contract, or as ordered by a court of law, or in compliance with Health Information Portability and Accountability Act (HIPAA), or as permitted by State or federal law, any such information to any party other than the Department without Department's prior written authorization specifying that the information may be released under Section 205.50 of Title 45 of the Code of Federal Regulations; Sections 10850 and 14100.2 of the Welfare and Institutions Code; and, regulations adopted pursuant thereto; and,

(4) At the termination of this Contract, maintain such information according to written procedures sent to Contractor by Department for this purpose.

8.10 Termination With or Without Cause

(a) Contractor may terminate this Contract, with or without cause, by written notice to the Department delivered in accordance with Paragraph 8.4. Termination will be effective thirty (30) calendar days after delivery or such date as set forth in the notice. Termination by Contractor under this paragraph will constitute Contractor's withdrawal from participation in the Health Care Coverage program.

(b) Department may terminate this Contract with or without cause, by written notice to the Contractor delivered in accordance with Paragraph 8.4. Termination will be effective thirty (30) calendar days after delivery or such date as set forth in the notice. Notwithstanding the foregoing, Contractor will first have the opportunity to cure whatever breach or other matter constitutes cause for termination. If contractor effectuates such cure prior to the expiration of the thirty (30) day notice period, this Contract will not terminate. If the nature of the cause for termination is such that is not reasonably susceptible of cure within thirty (30) days, then this Contract will not terminate so long as contractor has commenced a cure within said thirty (30) day period and thereafter diligently pursues it to completion.

(c) If changes to State or federal law, or changes in the applicable Demonstration requirements, result in a determination by either Department or Contractor that continued participation in the Health Care Coverage program is not in either party's best interests, then the party making such determination must provide written notice to the other, stating the notifying party's desire to terminate this Contract. The Department and Contractor will thereupon meet and confer within thirty (30) calendar days following such notice. If, following such meet and confer, either party still believes that it is not in its best interests for this Contract to remain in effect, then that party may terminate this Contract for cause upon an additional thirty (30) calendar days written notice.

(d) Contractor will remain entitled to reimbursement for all allowable costs of providing Covered Services and all allowable direct and indirect administrative costs incurred prior to the effective date of termination.

8.11 Automatic Termination

(a) This Contract will be terminated automatically upon the occurrence of either of the following events:

(1) If, at any time, Contractor ceases to operate its Health Care Coverage program.

(2) The Demonstration has been terminated by CMS.

(b) Contractor will remain entitled to reimbursement for all allowable costs of providing Covered Services and all allowable direct and indirect administrative costs incurred prior to the effective date of termination.

8.12 Health Information Portability and Accountability Act (HIPAA)

Contractor and Department must comply with HIPAA.

8.13 Provisions for Federally Funded Programs

Contractor agrees to comply with the provisions of Exhibit D, entitled Provisions for Federally Funded Programs which is by this reference made a part of this Contract.

SIGNATURES

The person signing this Contract on behalf of the Governmental Entity (Contractor) certifies that he/she is an administrator, officer or other individual duly authorized in a resolution by the governing board as having authority to sign on behalf of the Governmental Entity (Contractor), and is authorized and designated to enter into this Contract on behalf of the Governmental Entity (Contractor). This Contract will be deemed duly executed and binding upon execution by both parties below.

STATE OF CALIFORNIA
_____ Authorized Signatory Date _____
Nancy Hutchison, Chief Safety Net Financing Division Department of Health Care Services

GOVERNMENTAL ENTITY (CONTRACTOR)
_____ Authorized Signatory Date _____
John F. Schunoff, Interim Director County of Los Angeles, Department of Health Services

Additional Signatory (If applicable)

GOVERNMENTAL ENTITY (CONTRACTOR)
_____ Authorized Signatory Date _____
Name and Title of Signatory: _____ Agency Name:_____

Additional Signatory (If applicable)

GOVERNMENTAL ENTITY (CONTRACTOR)
_____ Authorized Signatory Date _____
Name and Title of Signatory: _____ Agency Name:_____

Exhibit A
Covered Services

Target Population

Age: 19-64

FPL: At or below 133.3% FPL

Other Characteristics: Chronic illness, age 63-64, or currently receiving uncoordinated care

Enrollment Fees (if applicable): NA

Premium (if applicable): NA

	Covered Service	Services Provided	Service Limits or caps	Cost Sharing (co-payments, co-insurance, or deductibles)
1.	Inpatient Hospital			
	General acute hospital			
	Psychiatric hospital			
	Inpatient drug and alcohol treatment			
	Acute rehabilitation hospital			
	Emergency room			
2.	Outpatient Hospital Services			
	Physician	X	None	None
	Optometry	X	None	None
	Psychology	X	None	None
	Podiatry	X	None	None
	Physical therapy	X	None	None
	Occupational therapy	X	None	None
	Speech therapy	X	None	None
	Audiology (includes hearing aids)	X	None	None
	Laboratory	X	None	None
	Radiology	X	None	None
	Prosthetic and orthotic devices	X	None	None
	Durable medical equipment	X	None	None
	Prescribed and over-the-counter drugs	X	None	None
	Medical supplies (includes incontinence supplies)	X	None	None

Exhibit A
Covered Services

	Covered Service	Services Provided	Service Limits or caps	Cost Sharing (co-payments, co-insurance, or deductibles)
	Use of hospital facilities[1]	X	None	None
	Outpatient drug therapy services	X	None	None
	Hemodialysis	X	None	None
3.	Clinic Services: rural health, federally qualified health centers (FQHC), FQHC look-alike, community, county, specialty clinics and State Licensed Free Clinic			
	Physician	X	None	None
	Optometry	X	None	None
	Psychology			
	Podiatry	X	None	None
	Physical therapy	X	None	None
	Occupational therapy	X	None	None
	Speech therapy	X	None	None
	Audiology (includes hearing aids)	X	None	None
	Laboratory	X	None	None
	Radiology	X	None	None
	Prosthetic and orthotic devices	X	None	None
	Durable medical equipment	X	None	None
	Prescribed and over-the-counter drugs	X	None	None
	Medical supplies (includes incontinence supplies)	X	None	None
	Outpatient drug therapy services	X	None	None
	Hemodialysis			
4.	Laboratory			
5.	Radiology (radiological services, portable imaging, and radioisotope services)			
6.	Nursing home care: Skilled nursing,			

[1] Including emergency room visits that do not result in an inpatient stay.

Exhibit A
Covered Services

	Covered Service	Services Provided	Service Limits or caps	Cost Sharing (co-payments, co-insurance, or deductibles)
	Intermediate Care			
7.	Subacute care facilities (licensed and certified skilled nursing)			
8.	Physician			
	Physician services			
	Dental services provided by a physician			
	Telemedicine			
	Smoking cessation			
	Sign language interpretation			
9.	Dental services (includes dentures)	X	Dentures not included	None
10.	Ophthalmology and optometry services, (includes eye glasses and optical fabricating laboratories)			
11.	Podiatry			
12.	Home health agency services:			
	Registered nurse			
	Licensed vocational nurse			
	Licensed therapist (physical, occupational, and speech)			
	Social worker			
	Home health aide			
	Psychology services			
	Infusion services			
	Medical supplies, equipment and appliances			
13.	Physical therapy			
14.	Occupational therapy			
15.	Speech therapy			
16.	Prosthetic appliances			

Exhibit A
Covered Services

	Covered Service	Services Provided	Service Limits or caps	Cost Sharing (co-payments, co-insurance, or deductibles)
17.	Orthotic appliances			
18.	Durable medical equipment			
19.	Non-physician practitioner services (midwives, family nurse practitioners, pediatric nurse practitioner, general nurse practitioner, physician assistants, and nurse anesthetist)			
20.	Personal care services			
21.	Nonemergency medical transportation			
22.	Acupuncture			
23.	Blood bank services			
24.	Outpatient hemodialysis and peritoneal dialysis			
25.	Audiology (includes hearing aids)			
26.	Indian health services			
27.	Ambulatory surgical center services	X	None	None
28.	Mental health services			
29.	Medical supplies (includes incontinence supplies)			

Exhibit B

Health Care Coverage Program Direct Service Providers

The following direct service providers have agreed to participate in the health care coverage program and provide health care services to the program enrollees.

Provider Name and Address

1. ANTELOPE VALLEY HEALTH CENTER
335-B E. AVENUE K-6
LANCASTER, CA 93535

2. BELLFLOWER HEALTH CENTER
10005 E. FLOWER STREET
BELLFLOWER, CA 90706

3. DOLLARHIDE HEALTH CENTER
1108 N. OLEANDER AVENUE
COMPTON, CA 90220

4. EDWARD R. ROYBAL COMPREHENSIVE HEALTH CENTER
245 S. FETTERLY AVENUE, ROOM 2251
LOS ANGELES, CA 90022

5. EL MONTE COMPREHENSIVE HEALTH CENTER
10953 RAMONA BLVD.
EL MONTE, CA 91731

6. VALLEYCARE GLENDALE HEALTH CENTER
501 N. GLENDALE AVENUE
GLENDALE, CA 91206

7. H. CLAUDE HUDSON COMPREHENSIVE CENTER
2829 S. GRAND AVENUE
LOS ANGELES, CA 90003

8. HIGH DESERT HEALTH SYSTEM
44900 N. 60TH STREET WEST
LANCASTER, CA 93536

9. HUBERT H. HUMPHREY COMPREHENSIVE HEALTH CENTER
5850 S. MAIN STREET
LOS ANGELES, CA 90003

Exhibit B

Health Care Coverage Program Direct Service Providers

10. LAKE LOS ANGELES COMMUNITY CLINIC
16921 E. AVENUE O, SPACE G
LAKE LOS ANGELES, CA 93591

11. LA PUENTE HEALTH CENTER
15930 CENTRAL AVENUE, ROOM 100
LA PUENTE, CA 91744

12. LITTLEROCK COMMUNITY CLINIC
8201 PEARBLOSSOM HIGHWAY
LITTLEROCK, CA 93543

13. LONG BEACH COMPREHENSIVE HEALTH CENTER
1333 CHESTNUT AVENUE
LONG BEACH, CA 90813

14. VALLEYCARE MID-VALLEY COMPREHENSIVE HEALTH CENTER
7515 VAN NUYS BLVD.
VAN NUYS, CA 91405

15. VALLEYCARE SAN FERNANDO HEALTH CENTER
1212 PICO STREET
SAN FERNANDO, CA 91340

16. SOUTH ANTELOPE VALLEY HEALTH CENTER
38350 40TH STREET EAST
PALMDALE, CA 93552

17. WILMINGTON HEALTH CENTER
1325 BROAD AVENUE
WILMINGTON, CA 90744

18. ALL FOR HEALTH, HEALTH FOR ALL, INC.
519 E. BROADWAY
GLENDALE, CA 91205

19. ARROYO VISTA FAMILY HEALTH FOUNDATION
6000 N. FIGUEROA ST.
LOS ANGELES, CA 90042

Exhibit B

Health Care Coverage Program Direct Service Providers

20. ARROYO VISTA FAMILY HEALTH FOUNDATION
4815 E. VALLEY BLVD. #D
LOS ANGELES, CA 90032

21. ARROYO VISTA FAMILY HEALTH FOUNDATION
2411 N. BROADWAY
LOS ANGELES, CA 90031

22. ASIAN PACIFIC HEALTH CARE VENTURE
1530 HILLHURST AVE, #200
LOS ANGELES, CA 90027

23. CENTRAL CITY COMMUNITY HEALTH CENTER
5970 SOUTH CENTRAL AVE.
LOS ANGELES, CA 90001

24. CHINATOWN SERVICE CENTER
767 N. HILL ST., SUITE 200
LOS ANGELES, CA 90012

25. CLINICA MSR. OSCAR ROMERO
123 SOUTH ALVARADO ST.
LOS ANGELES, CA 90057

26. CLINICA MSR. OSCAR ROMERO
2032 MARENGO ST.
LOS ANGELES, CA 90033

27. COMMUNITY HEALTH ALLIANCE OF PASADENA
1855 NORTH FAIR OAKS AVE., SUITE 200
PASADENA, CA 91103

28. EAST VALLEY COMMUNITY HEALTH CENTER
420 SOUTH GLENDORA AVE.
WEST COVINA, CA 91790

29. EAST VALLEY COMMUNITY HEALTH CENTER
680 FAIRPLEX DR.
POMONA, CA 91768

Exhibit B

Health Care Coverage Program Direct Service Providers

30. EISNER PEDIATRIC & FAMILY MEDICAL CENTER
1530 SOUTH OLIVE STREET
LOS ANGELES, CA 90015

31. EL PROYECTO DEL BARRIO
8902 WOODMAN AVE.
ARLETA, CA 91331

32. EL PROYECTO DEL BARRIO
20800 SHERMAN WAY
CANOGA PARK, CA 91306

33. EL PROYECTO DEL BARRIO
150 N. AZUSA AVE.
AZUSA, CA 91702

34. FAMILY HEALTH CARE CENTERS OF GREATER LA
6501 S. GARFIELD AVE.
BELL GARDENS, CA 90201

35. FAMILY HEALTH CARE CENTERS OF GREATER LA
22310 WARDHAM AVE.
HAWAIIAN GARDENS, CA 90716 (TO)

36. HARBOR FREE CLINIC
593 W. 6TH ST.
SAN PEDRO, CA 90731

37. HARBOR FREE CLINIC
731 S. BEACON ST.
SAN PEDRO, CA 90731 (CL)

38. JWCH INSTITUTE, INC.
1910 W. SUNSET BLVD., SUITE 650
LOS ANGELES, CA 90026

39. JWCH INSTITUTE, INC.
721 E. 5TH ST.
LOS ANGELES, CA 90013

40. JWCH INSTITUTE, INC.
6912 AJAX AVE.
BELL GARDENS, CA 90201

Exhibit B

Health Care Coverage Program Direct Service Providers

41. **JWCH INSTITUTE, INC.**
12360 FIRESTONE BLVD.
NORWALK, CA 90650

42. **JWCH INSTITUTE, INC.**
340 N. MADISON AVE.
LOS ANGELES, CA 90004

43. **JWCH INSTITUTE, INC.**
515 E. 6TH ST.
LOS ANGELES, CA 90021

44. **KOREAN HEALTH, EDUCATION, INFO & RESEARCH**
3727 W. 6TH STREET
LOS ANGELES, CA 90020

45. **MISSION CITY COMMUNITY NETWORK**
15206 PARTHENIA STREET
NORTH HILLS, CA 91343

46. **MISSION CITY COMMUNITY NETWORK**
4842 HOLLYWOOD BLVD.
LOS ANGELES, CA 90027

47. **NORTHEAST COMMUNITY CLINIC**
2550 WEST MAIN STREET, SUITE 301
ALHAMBRA, CA 91801

48. **NORTHEAST COMMUNITY CLINIC**
5564 N. FIGUEROA ST.
LOS ANGELES, CA 90042

49. **NORTHEAST COMMUNITY CLINIC**
4129 E. GAGE AVE.
BELL, CA 90201

50. **NORTHEAST COMMUNITY CLINIC**
1414 S. GRAND AVE., 2ND FL.
LOS ANGELES, CA 90015

Exhibit B

Health Care Coverage Program Direct Service Providers

51. **NORTHEAST COMMUNITY CLINIC**
3751 S. HARVARD BLVD.
LOS ANGELES, CA 90018

52. **NORTHEAST COMMUNITY CLINIC**
231 W. VERNON AVE., STE. 203
LOS ANGELES, CA 90037

53. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
1300 N. VERMONT AVE SUITE 1002
LOS ANGELES, CA 90027

54. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
4448 YORK BLVD.
LOS ANGELES, CA 90041

55. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
150 N. RENO ST.
LOS ANGELES, CA 90026

56. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
3242 W. 8TH ST.
LOS ANGELES, CA 90005

57. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
4618 FOUNTAIN AVE.
LOS ANGELES, CA 90028

58. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
133 N. SUNOL DR.
LOS ANGELES, CA 90063

59. **FRANCISCAN CLINICS dba QUEENSCARE FAMILY CLINICS**
184 S. BIMINI PLACE
LOS ANGELES, CA 90004

60. **LA FREE CLINIC dba SABAN FREE CLINIC**
8405 BEVERLY BLVD.,
LOS ANGELES, CA 90048

Exhibit B

Health Care Coverage Program Direct Service Providers

61. LA FREE CLINIC dba SABAN FREEE CLINIC
6043 HOLLYWOOD BLVD.
LOS ANGELES, CA 90028

62. LA FREE CLINIC dba SABAN FREEE CLINIC
5205 MELROSE AVE.
LOS ANGELES, CA 90038 (CL)

63. LA FREE CLINIC dba SABAN FREEE CLINIC
1926 W. BEVERLY BLVD.,
LOS ANGELES, CA 90057

64. SOUTH BAY FAMILY HEALTHCARE CENTER
23430 HAWTHORNE BLVD., #210
TORRANCE, CA 90505

65. SOUTH BAY FAMILY HEALTHCARE CENTER
742 WEST GARDENA BLVD.
GARDENA, CA 90247

66. SOUTH BAY FAMILY HEALTHCARE CENTER
1091 S. LA BREA
INGLEWOOD, CA 90301

67. SOUTH BAY FAMILY HEALTHCARE CENTER
2114 ARTESIA BLVD.
REDONDO BEACH, CA 90278

68. SOUTH CENTRAL FAMILY HEALTH CENTER
4425 S. CENTRAL AVENUE
LOS ANGELES, CA 90011

69. SOUTH CENTRAL FAMILY HEALTH CENTER
4000 SOUTH MAIN ST.
LOS ANGELES, CA 90011

70. ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.
5701 S. HOOVER STREET
LOS ANGELES, CA 90037

Exhibit B

Health Care Coverage Program Direct Service Providers

71. ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.
2115 N. WILMINGTON AVE.
COMPTON, CA 90222

72. ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.
2300 S. FLOWER, STE. 303
LOS ANGELES, CA 90007

73. ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.
515 W. 27th ST.
LOS ANGELES, CA 90007

74. ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.
2512 N. ALTA ST.
LOS ANGELES, CA 90031

75. T.H.E. CLINIC, INC.
3834 S. WESTERN AVE
LOS ANGELES, CA 90062

76. TARZANA TREATMENT CENTER
8330 RESEDA BLVD.
NORTHRIDGE, CA 91324

77. TARZANA TREATMENT CENTER
907 W. LANCASTER BLVD.
LANCASTER, CA 93534

78. TARZANA TREATMENT CENTER
8330 TARZANA BLVD.
RESEDA, CA 91325

79. THE CHILDREN'S CLINIC
2801 ATLANTIC AVE.
LONG BEACH, CA 90801

80. THE CHILDREN'S CLINIC
455 COLUMBIA ST, STE 201
LONG BEACH , CA 90801

Exhibit B

Health Care Coverage Program Direct Service Providers

81. THE CHILDREN'S CLINIC
1057 PINE AVENUE
LONG BEACH, CA 90813

82. THE CHILDREN'S CLINIC
1060 EAST 70TH STREET
LONG BEACH, CA 90805

83. THE CHILDREN'S CLINIC
730 WEST 3RD ST.
LONG BEACH , CA 90802

84. THE CHILDREN'S CLINIC
1301 WEST 12TH ST.
LONG BEACH, CA 90813

85. VALLEY COMMUNITY CLINIC
6801 COLDWATER CANYON
NORTH HOLLYWOOD, CA 91605

86. VENICE FAMILY CLINIC
2509 PICO BLVD.
SANTA MONICA, CA 90405

87. VENICE FAMILY CLINIC
4909 MARIONWOOD DR.
CULVER CITY, CA 90231

88. VENICE FAMILY CLINIC
604 ROSE AVENUE
VENICE , CA 90291

89. VENICE FAMILY CLINIC
905 VENICE BLVD.
VENICE , CA 90291

90. VENICE FAMILY CLINIC
323 S. LINCOLN BLVD.
VENICE , CA 90291

Exhibit B

Health Care Coverage Program Direct Service Providers

91. WATTS HEALTHCARE CORPORATION
10300 COMPTON AVE.
LOS ANGELES, CA 90002

92. WATTS HEALTHCARE CORPORATION
3756 SANTA ROSALIA DR #400
LOS ANGELES , CA 90008

93. WESTSIDE FAMILY HEALTH CENTER
1711 OCEAN PARK BLVD.
SANTA MONICA, CA 90405

94. WESTSIDE NEIGHBORHOOD CLINIC
2125 SANTA FE AVE
LONG BEACH, CA 90810

95. WILMINGTON COMMUNITY CLINIC
1009 N. AVALON BLVD.
WILMINGTON, CA 90744

SERVICES WILL BE PROVIDED IN THE OUTPATIENT DEPARTMENTS OF THE FOLLOWING COUNTY HOSPITALS

96. HARBOR/UCLA MEDICAL CENTER
1000 W. CARSON ST.
TORRANCE, CA 90509

97. LAC+USC MEDICAL CENTER
1200 N. STATE ST.
LOS ANGELES, CA 90033

98. OLIVE VIEW/UCLA MEDICAL CENTER
14445 OLIVE VIEW DR.
SYLMAR, CA 91342

99. RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
7601 E. IMPERIAL HIGHWAY
DOWNEY, CA 90242

Exhibit B

Health Care Coverage Program Direct Service Providers

CONTRACTS UNDER NEGOTIATION

100. ALL FOR HEALTH, HEALTH FOR ALL, INC.
520 E. BROADWAY
GLENDALE, CA 91205

101. ALTAMED HEALTH SERVICES CORPORATION
500 CITADEL DRIVE, SUITE 490
LOS ANGELES, CA 90040

102. ALTAMED HEALTH SERVICES CORPORATION
10454 E. VALLEY BLVD.
EL MONTE, CA 91731

103. ALTAMED HEALTH SERVICES CORPORATION
9436 E. SLAUSON
PICO RIVERA, CA 90660

104. ALTAMED HEALTH SERVICES CORPORATION
5427 WHITTIER BLVD., SUITE 101
LOS ANGELES, CA 90022

105. ALTAMED HEALTH SERVICES CORPORATION
1701 ZONAL AVE.
LOS ANGELES, CA 90033

106. ALTAMED HEALTH SERVICES CORPORATION
6901 S. ATLANTIC AVENUE
BELL, CA 90201

107. ALTAMED HEALTH SERVICES CORPORATION
3945 E. WHITTIER BLVD.
LOS ANGELES, CA 90023

108. ALTAMED HEALTH SERVICES CORPORATION
5427 WHITTIER BLVD., STE. 101
LOS ANGELES, CA 90022

109. ANTELOPE VALLEY COMMUNITY CLINIC
1122 WEST AVENUE L-12, SUITE 103,
LANCASTER, CA 93534

Exhibit B

Health Care Coverage Program Direct Service Providers

110. BAART COMMUNITY HEALTHCARE
15229 E. AMAR RD.,
LA PUENTE, CA 91744-2066

111. BAART COMMUNITY HEALTHCARE
4920 S. AVALON
LOS ANGELES, CA 90011

112. BAART COMMUNITY HEALTHCARE
1926 W. BEVERLY BLVD.
LOS ANGELES, CA 90057

113. COMMUNITY HEALTH ALLIANCE OF PASADENA
3160 EAST DEL MAR AVENUE
PASADENA, CA 91107

114. COMPREHENSIVE COMMUNITY HEALTH CENTERS
801 S. CHEVY CHASE DR., #250
GLENDALE, CA 91205

115. COMPREHENSIVE COMMUNITY HEALTH CENTERS
12157 VICTORY AVE.
NORTH HOLLYWOOD, CA 91605

116. COMPTON CENTRAL HEALTH CLINIC, INC.
201 N. CENTRAL AVE.
COMPTON, CA 90220

117. DURFEE FAMILY CARE MEDICAL GROUP
2006 DURFEE AVE.
EL MONTE, CA 91733

118. EL PROYECTO DEL BARRIO
8902 WOODMAN AVENUE
ARLETA, CA 91331

119. GARFIELD HEALTH CENTER
210 N. GARFIELD AVE., STE. 203
MONTEREY PARK, CA 91754

Exhibit B

Health Care Coverage Program Direct Service Providers

120. JWCH INSTITUTE, INC.
5725 SOTO STREET
HUNTINGTON PARK, CA 90255

121. NORTHEAST COMMUNITY CLINIC
714 NORTH AVALON B3
WILMINGTON, CA 90744

122. NORTHEAST VALLEY HEALTH CORPORATION
7843 LANKERSHIM BOULEVARD
NORTH HOLLYWOOD, CA 91605

123. NORTHEAST VALLEY HEALTH CORPORATION
7330 BACKMAN AVENUE
SUN VALLEY, CA 91352

124. POMONA VALLEY HOSPITAL MEDICAL CENTER
750 S. PARK AVE.,
POMONA, CA 91766

125. POMONA VALLEY HOSPITAL MEDICAL CENTER
887 E. SECOND ST., SUITE C
POMONA , CA 91766

126. SACRED HEART FAMILY MEDICAL CLINICS, INC.
8540 ALONDRA BLVD., SUITE B2
PARAMOUNT, CA 90723

127. UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC.
711 W. FLORENCE AVE
LOS ANGELES, CA 90044

128. WILMINGTON COMMUNITY CLINIC
10901 SOUTH VERMONT AVENUE
LOS ANGELES, CA 90044

Exhibit C
Covered Services Maximum Cost Sharing

	Covered Services	Maximum Cost Sharing (co-payments, co-insurance, or deductibles)
1.	Inpatient Hospital	
	General acute hospital	Maximum of $550/admission plus 35% of full charges; possible lien on property possessed or acquired in the future
	Psychiatric hospital	Maximum of $500/admission
	Inpatient drug and alcohol treatment	None
	Acute rehabilitation hospital	0-100% FPL - $50/admission 101-200% FPL - $100/admission
	Emergency room	$100 per visit
2.	Outpatient Hospital Services	
	Physician	$20/visit
	Optometry	$20/visit
	Psychology	$20/visit
	Podiatry	$20/visit
	Physical therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
	Occupational therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
	Speech therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
	Audiology (includes hearing aids)	$20/visit
	Laboratory	$5/visit equal to or less than 100% FPL
	Radiology	$25/diagnostic service; $50/CT, ultrasound or ECG; $150/MRI
	Prosthetic and orthotic devices	50% of cost
	Durable medical equipment	50% of cost
	Prescribed and over-the-counter drugs	$5/prescription under $50; $15/prescription between $50 and $200; 20% of cost for prescription over $200, with maximum of $100/prescription
	Medical supplies (includes incontinence supplies)	$10
	Use of hospital facilities	0-100% FPL - $5/visit 101-200% FPL - $100/visit Co-pay $100 for first 5 days, $25 each additional day, Max of $500 per admission, outpatient surgery co-pay sliding scale fee (0-25% of Medicare fee)

Exhibit C
Covered Services Maximum Cost Sharing

	Covered Services	Maximum Cost Sharing (co-payments, co-insurance, or deductibles)
	Outpatient drug therapy services	$100/treatment
	Hemodialysis	0-100% FPL - $15/visit 101-200% FPL - $25/visit
3.	Clinic Services: rural health, federally qualified health centers (FQHC), FQHC look-alike, community, county, specialty clinics and State Licensed Free Clinic	
	Physician	$20/visit
	Optometry	$20/visit
	Psychology	$20/visit
	Podiatry	$20/visit
	Physical therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
	Occupational therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
	Speech therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
	Audiology (includes hearing aids)	$20/visit
	Laboratory	$5/visit
	Radiology	$25/diagnostic service; $50/CT, ultrasound or ECG; $150/MRI
	Prosthetic and orthotic devices	50% of cost
	Durable medical equipment	50% of cost
	Prescribed and over-the-counter drugs	$5/prescription under $50; $15/prescription between $50 and $200; 20% of cost for prescription over $200, with maximum of $100/prescription
	Medical supplies (includes incontinence supplies)	$10
	Outpatient drug therapy services	$100/treatment
	Hemodialysis	$25/visit 101% FPL and over
4.	Laboratory	$5/visit 101% FPL and over
5.	Radiology (radiological services, portable imaging, and radioisotope services)	$25/diagnostic service; $50/CT, ultrasound or ECG
6.	Nursing home care: Skilled nursing, Intermediate Care	None
7.	Subacute care facilities (licensed and certified skilled nursing)	$100/inpatient visit 101% FPL and over
8.	Physician	

Exhibit C
Covered Services Maximum Cost Sharing

	Covered Services	Maximum Cost Sharing (co-payments, co-insurance, or deductibles)
	Physician services	$20/visit; $50/visit for specialist
	Dental services provided by a physician	$20/visit; $100 for oral surgery
	Telemedicine	None
	Smoking cessation	$5/box of patches
	Sign language interpretation	$10/visit
9.	Dental services (includes dentures)	$20/visit for basic services, restorative and periodontics; $100/oral surgery $30/visit + 80% UCR for major restorative
10.	Ophthalmology and optometry services, (includes eye glasses and optical fabricating laboratories)	0-100% FPL - $10/visit 101-200% FPL - $20/visit
11.	Podiatry	$20/visit
12.	Home health agency services:	
	Registered nurse	$5/visit 101% FPL and over
	Licensed vocational nurse	$5/visit 101% FPL and over
	Licensed therapist (physical, occupational, and speech)	$5/visit 101% FPL and over
	Social worker	$5/visit 101% FPL and over
	Home health aide	$5/visit 101% FPL and over
	Psychology services	None
	Infusion services	None
	Medical supplies, equipment and appliances	None
13.	Physical therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
14.	Occupational therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
15.	Speech therapy	0-100% FPL - $15/visit 101-200% FPL - $20/visit
16.	Prosthetic appliances	50% of cost
17.	Orthotic appliances	$10
18.	Durable medical equipment	50% of cost
19.	Non-physician practitioner services (midwives, family nurse practitioners, pediatric nurse practitioner, general nurse practitioner, physician assistants, and nurse anesthetist)	$20/visit
20.	Personal care services	None

Exhibit C

Covered Services Maximum Cost Sharing

	Covered Services	Maximum Cost Sharing (co-payments, co-insurance, or deductibles)
21.	Nonemergency medical transportation	None
22.	Acupuncture	0-100% FPL - none 101-200% FPL - $5/visit
23.	Blood bank services	$15
24.	Outpatient hemodialysis and peritoneal dialysis	0-100% FPL-$5/visit, 101-200% FPL-$10/visit
25.	Audiology (includes hearing aids)	$10/visit
26.	Indian health services*	0-100% FPL - $5/visit 101-200% FPL - $10/visit
27.	Ambulatory surgical center services	Maximum of $550/admission plus 35% of full charges; possible lien on property possessed or acquired in the future
28.	Mental health services	$20/visit
29.	Medical supplies (includes incontinence supplies)	$10

* No federal co-pay will be allowed if the Indian health services provider is a recognized Indian Health Center.

Exhibit D
Provisions for Federally Funded Programs

Fair Employment Practices

a) In the performance of this Contract, the Contractor must not discriminate against any employee or applicant for employment because of race, color, religion, ancestry, sex, age, national origin, physical handicap, mental condition, sexual orientation, or marital status. The Contractor must take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, color, religion, ancestry, sex, age, national origin, mental condition, physical handicap, marital status, or sexual orientation. Such action must include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising, layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor must post in conspicuous places, available to employees and applicants for employment, notices to be provided by the State setting forth the provisions of this Fair Employment Practices section.

b) The Contractor must permit access to his records of employment, employment advertisements, application forms, and other pertinent data and records by the State Fair Employment and Housing Commission, or any other agency of the State of California designated by the State, for the purposes of investigation to ascertain compliance with the Fair Employment Practices section of this Contract.

c) Remedies for Unlawful Employment Practice:

(1) The State may determine an unlawful practice under the Fair Employment Practices section of this Contract to have occurred upon receipt of a final judgment having that effect from a court in an action to which Contractor was a party, or upon receipt of a written notice from the Fair Employment and Housing Commission that it has investigated and determined that the Contractor has violated the provisions of the Fair Employment and Housing Act and has issued an order, under Government Code Section 12970, which has become final.

(2) For unlawful practices under this Fair Employment Practices section, the State must have the right to terminate this Contract after a determination pursuant to (c) (1) of this section has been made.

Any loss or damage sustained by the State in securing a replacement Contractor to render the services contracted for under this Contract will be borne and paid for by the Contractor and the State may deduct from any moneys due to that thereafter may become due to the Contractor, the difference between the price named in the contract and the actual cost thereof to the State.

d) Contractor agrees to comply with Title 2, Division 3, Part 2.8 (Government Code Sections 12900 et seq.), and any amendments thereto, and any regulation adopted pursuant to that part.

Exhibit D
Provisions for Federally Funded Programs

Nondiscrimination in Services, Benefits and Facilities

a) The Contractor must not discriminate in the provision of services because of race, color, religion, national origin, sex, age, mental or physical handicap or sexual orientation as provided by state and federal law.

b) For the purposes of this Contract, distinctions on the grounds of race, color, religion, national origin, age or mental or physical handicap or sexual orientation include but are not limited to the following: denying a beneficiary any service or benefit which is different, or is provided in a different manner or at a different time from that provided other beneficiaries under this Contract; subjecting a beneficiary to segregation or separate treatment in any matter related to his receipt of any service; restricting a beneficiary in any way in the enjoyment, advantage or privilege enjoyed by others receiving any service or benefit; treating a beneficiary differently from others in determining whether the beneficiary satisfied any admission, eligibility, other requirement or condition which individuals must meet in order to be provided any benefit; the assignment of times or places for the provision of services on the basis of the race, color, religion, national origin, age, mental or physical handicap or sexual orientation of the beneficiaries to be served.

c) The Contractor must take affirmative action to ensure that services to intended beneficiaries are provided without regard to race, color, religion, national origin, sex, age, mental or physical handicap or sexual orientation.

Clean Air and Water

(This Paragraph is applicable only if the Contract exceeds $100,000, or the Federal Contracting Officer or State has determined that orders under an indefinite quantity contract in any one year will exceed $100,000, or a facility to be used has been the subject of a conviction under the Clean Air Act (42 U.S.C. 1857c-8[c] [1]) or the Federal Water Pollution Control Act (33 U.S.C. 1319[c]) and is listed by EPA, or the contract is not otherwise exempt.)

a) The Contractor agrees as follows:

1) To comply with all the requirements of Section 114 of the Clean Air Act, as amended (42 U.S.C. 1857, et seq., as amended by Pub.L., 91-604) and Section 308 of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq., as amended by Pub.L., 92-500), respectively relating to inspection monitoring, entry, reports, and information, as well as other requirements specified in Section 114 and Section 308 of the Air Act and the Water Act, respectively, and all regulations and guidelines issued there under before the award of this Contract.

2) No obligation required by this Contract will be performed in a facility listed on the Environmental Protection Agency List of Violating Facilities on the date when this contract was executed unless and until the EPA eliminates the name of such facility or facilities from such listing.

3) To use its best efforts to comply with clean air standards and clean water standards at the facility in which the services are being performed.

4) To insert the substance of the provisions of this Paragraph into any written delegation.

b) The terms used in this Paragraph have the following meanings:

1) The term "Air Act" means the Clean Air Act, as amended (42 U.S.C. 1857 et seq., as amended by Pub.L., 91-604).

2) The terms "Water Act" means Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 et seq., as amended by Pub.L., 92-500).

3) The term "clean air standards" means any enforceable rules, regulations, guidelines, standards, limitations, orders, controls, prohibitions, or other which are contained in, issued under, or otherwise adopted pursuant to the Air Act or Executive Order 11738, an approved implementation procedure or plan under section 110(d) of the Clean Air Act (42 U.S.C. 1857c-5[d]), an approved implementation procedure or plan under section 111(c) or section 111(d), or an approved implementation procedure under section 112(d) of the Air Act (42 U.S.C. 1857c-7[d]).

4) The terms "clean water standards" means any enforceable limitation, control, condition, prohibition, standard, or other requirement which is promulgated pursuant to the Water Act or contained in a permit issued to a discharger by the Environmental Protection Agency or by a state under an approved program, as authorized by Section 402 of the Water Act (33 U.S.C. 1317).

(5) The term "compliance" means compliance with clean air or water standards. Compliance must also mean compliance with a schedule or plan ordered or approved by a court of competent jurisdiction, the Environmental Protection Agency or an air or water pollution control agency in accordance with the requirements of the Air Act or Water Act and regulations issued pursuant thereto.

(6) The term "facility" means any building, plant, installation, structure, mine, vessel or other floating craft, location, or site of operations, owned, leased, or supervised by a Contractor. Where a location or site of operations contains or

includes more than one building, plant, installation, or structure, the entire location or site must be deemed to be a facility except where the Director, Office of Federal Activities, Environmental Protection Agency, determines that independent facilities are collected in one geographical area.

Utilization of Small Business Concerns

(a) It is the policy of the Federal Government and the State as declared by the Congress and the State Legislature that a fair proportion of the purchases and contracts for supplies and services for the State be placed with small business concerns.

(b) The Contractor must accomplish the maximum amount of delegation to, and purchase of goods or services from, small business concerns that the Contractor finds to be consistent with the efficient performance of this Contract.

Provision of Bilingual Services

(a) When the community potentially served by the Contractor consists of non-English or limited-English speaking persons, the Contractor must take all steps necessary to develop and maintain an appropriate capability for communicating in any necessary second language, including, but not limited to the employment of, or contracting for, in public contact positions of persons qualified in the necessary second languages in a number sufficient to ensure full and effective communication between the non-English and limited-English speaking applicants for, and beneficiaries of, the facility's services and the facility's employees.

Contractor may comply with this Paragraph by providing sufficient qualified translators to provide translation in any necessary second language for any patient, caller or applicant for service, within ten minutes of need for translation. Contractor must maintain immediate translation capability in the emergency room when five percent of the emergency room patients or applicants for emergency room services are non-English or limited-English speaking persons.

Contractor must provide immediate translation to non-English or limited-English speaking patients whose condition is such that failure to immediately translate would risk serious impairment. Contractor must post notices in prominent places in the facility of the availability of translation in the necessary second languages.

(b) As used in this Paragraph:

(1) "Non-English or limited-English speaking persons" refers to persons whose primary language is a language other than English;

Exhibit D
Provisions for Federally Funded Programs

(2) "Necessary second language" refers to a language, other than English, which is the primary language of at least five percent (5%) of either the community potentially served by the contracting facility or of the facility's patient population;

(3) "Community potentially served by the contracting facility" refers to the geographic area from which the facility derives eighty percent (80%) of its patient population; and

(4) "Qualified translator" is a person fluent in English and in the necessary second language, familiar with medical terminology, and who can accurately speak, read, write and readily interpret in the necessary second language.

Federal Contract Funds

a) It is mutually understood between the parties that this Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Contract were executed after the determination was made.

b) This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Contract. In addition this Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Contract in any manner.

c) It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Contract shall be amended to reflect any reduction in funds.

d) Department has the option to invalidate or cancel the Contract with thirty (30) calendar days advance written notice or to amend the Contract to reflect any reduction in funds.

Exhibit E
Maintenance-of-Effort

This Exhibit assists Contractor and Department in assuring compliance with the maintenance-of-effort (MOE) requirement applicable to the Coverage Initiative Program.

1. **Identify the total amount of non-federal funds expended for health care services during State Fiscal Year (SFY) 2006-07 that was not reimbursed by any other payor, using Medicare cost principles.**

Total non-federal funds expenditures should include expenditures that:

- Provide health care services (such as hospital, clinic, physician, dental, or other such services) other than for individuals covered by Medicaid, Medicare, private insurance or other payor sources.

- Are from any payment source (e.g., county general purpose funds, state realignment funds, borrowed funds, and carryover funds from prior years).

Total non-federal funds expenditures should not include expenditures that are:

- Made from grants from a particular source which are specifically targeted for a particular purpose or program.

- For capital investments in health care facilities.

- For all public health functions.

The intent is to identify expenditures for health care services that are similar to those to be made as part of the Coverage Initiative Program.

Total non-federal funds expenditures for SFY 2006-2007
$ 990,268,742

* Contractor must provide a worksheet showing the budget or expenditure accounts and expenditure amounts used to determine the amount reported.

2. **Identify any extraordinary and non-recurring expenditures incurred for health care services during SFY 2006-07.**

The intent is to identify truly unusual expenditures for health care services that are not expected to be repeated. Examples include expenditures to respond to a health epidemic, or expenditures from substantial special funds. Contractor shall discuss with Department any expenditure identified under this section and Department will make the final determination whether the expenditure will be excluded from the baseline.

Total amount of extraordinary and non-recurring expenditures during SFY 2006-07:
$ 209,628,000

*Contractor must provide a list of the extraordinary and non-recurring expenditures.

3. **Baseline expenditures for health care services for SFY 2006-07 (Section 1. minus Section 2.):**
$ 780,640,742

4. **Determine the portion of SFY 2006-07expenditures reported in Section 3. for health care services provided to individuals who would have been eligible for the Coverage Initiative Program. (This step will not be necessary if costs related to ineligible groups were excluded in Section 1.)**

Department does not specify any particular methodology for determining this amount. However, Contractor must provide documentation demonstrating the methodology used to arrive at this amount.

5. **MOE requirement:** **$ 641,764,753**

Contractor's MOE requirement will be reduced by the amount of any reduction in the State's level of contribution of realignment funds to the Contractor's health account for SFYs 2007-08, 2008-09, and 2009-10. However, Federal funding for the Coverage Initiative may be reduced as a result of a reduction in Contractor's MOE requirement.

Notes to Item No. 1.

The sources of data are the reports submitted by the Contractor under Attachment F to the Special Terms and Conditions of the Demonstration (also known as the "Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool" or the "Paragraph 14 Document") and related reports from Contractor's records, as necessary. Final determinations under Paragraph 3.4 and this Exhibit E shall be based on these final reports for each project year, both for determining the base year MOE amount and for annual determinations of compliance.

Item No. 1 includes expenditures for all health services provided by the County Department of Health Services, including inpatient and outpatient hospital services, but excluding public health services provided by the County Department of Public Health and mental health services provided by the County Department of Mental Health.

Expenditures are not offset by Safety Net Care Pool or Disproportionate Share Hospital funds.

Notes to Item No. 2.

Extraordinary expenditures from the following, non-recurring sources have been applied exclusively to services for the uninsured:

Amounts in the Department of Health Services Designation fund balance that were derived in substantial part from prior year payments under the Medicaid Demonstration Project for Los Angeles County (No. 11-W-00076/9) and under the Emergency Services and Supplemental Payments program (SB 1255). (For the base year, State fiscal year 2006-07 this amount is $123,570,000; and for State fiscal year 2007-08 this amount is estimated to be $27,260,000.)

One-time County General fund contribution in the base year, State fiscal year 2006-07, in the amount of $86,058,000.

Notes on Item No. 4.

It is assumed for the base year and for the term of this Agreement that 82.21% of the Contractor's uninsured patient population are U.S. citizens or otherwise have satisfactory immigration status as required under the Special Terms and Conditions of the Demonstration.

For purposes of determining the MOE amount, and for purposes of determining compliance with the MOE requirement during the term of this Agreement, the MOE amount is not reduced to reflect other of Contractor's Coverage Initiative program eligibility requirements relating to age, income, or target population characteristics.

Notes on Item No. 5.

The MOE calculation is attached to, and incorporated in, this Exhibit E.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

Exhibit E

Maintenance-of-Effort

FISCAL YEAR 2006-07

1. **Identify the total amount of non-federal funds expended for health care services during State Fiscal Year (SFY) 2006-07 that was not reimbursed by any other payor, using Medicare cost principles.**

	Uninsured Inpatient & Outpatient Costs (1)	Non-Recurring Expenditures	Net	Documented %	Documented Costs
LAC+USC Medical Center	355,348,879	75,223,090	280,125,789	82.21%	$230,291,411
H/UCLA Medical Center	152,486,422	32,279,544	120,206,878	82.21%	98,822,074
MLK-H Hospital	105,870,460	22,411,505	83,458,955	82.21%	68,611,607
Rancho Los Amigos National Rehab Center	31,178,288	6,600,069	24,578,219	82.21%	20,205,754
OV/UCLA Medical Center	126,101,992	26,694,277	99,407,715	82.21%	81,723,083
LAC+USC Healthcare Network CHC/HC	71,540,028	15,144,165	56,395,863	82.21%	46,363,039
Coastal CHC/HC	20,087,141	4,252,207	15,834,934	82.21%	13,017,899
Southwest CHC/HC	30,418,979	6,439,333	23,979,646	82.21%	19,713,667
San Fernando CHC/HC	19,451,346	4,117,616	15,333,730	82.21%	12,605,859
Antelope Valley Area (Includes HDMACC & AVHCs)	24,153,378	5,112,980	19,040,398	82.21%	15,653,111
PPP	53,631,829	11,353,214	42,278,615	82.21%	34,757,249
Total	**$990,268,742**	**$209,628,000**	$780,640,742		$641,764,753

(1) Hospital = P. 14, Schedule 1, Column 5b, Line A. CHC/HC/MACC/JCHS = P. 14, Schedule 4

Note: There are no Public Health costs in these amounts.

2. **Identify any extraordinary and non-recurring expenditures incurred for health care services during SFY 2006-07.**

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES						
Exhibit E						
Maintenance-of-Effort						
FISCAL YEAR 2006-07						
	Local Property Tax/County Contribution, portion of	$ 86,058,000	One time County Funds			
	Fund Balance	123,570,000				
	Total	**$209,628,000**				
	Source: Financial Performance Analysis, Department Summary, Fiscal Year 2006-07					
3.	**Baseline expenditures for health care services for SFY 2006-07 (Section 1. minus Section 2.)**					
	Total	**$780,640,742**				
4.	**Determine the portion of SFY 2006-07 expenditures reported in Section 3. for health care services provided to individuals who would have been eligible for the Coverage Initiative Program. (This step will not be necessary if costs related to ineligible groups were excluded in Section 1.)**					
5.	**MOE requirement:**	**$641,764,753**				